For that and other reasons, MSOP has come under harsh criticism in recent years. In 2011, some of MSOP’s clients filed a class action lawsuit in federal court claiming, among other things, that the state’s process of indefinite civil commitment violates their constitutional right to due process. Also in 2011, the state legislative auditor’s office released a report questioning the validity of the civil commitment process and stating that frequent changes in leadership at MSOP since 2003 have affected its ability to maintain the consistency and continuity of its treatment program. With each change in leadership, clients and clinicians have had to learn a new treatment protocol and clients have had to be reassessed against the new program’s guidelines. The report also cited MSOP’s excessive cost and its failure to release patients who pose little or no threat to the community.

The state of the state

Minnesota is one of 20 states that use indefinite civil commitment—court-ordered commitment to treatment in a hospital (see next page)—to confine sex offenders who have served their prison sentences. In 2010, when the legislative auditor’s report was compiled, the state had the third-largest population of civilly committed sex offenders in the country, following California and Florida, and the highest number of civilly committed offenders per capita. “In a decade we’ve released one person. Minnesota’s clearly an outlier,” says Michael Miner, Ph.D., director of research in the University of Minnesota’s department of family medicine and community health’s Program in Human Sexuality and

View from the Hotel California

Is it possible to rehabilitate Minnesota’s most serious sex offenders?

BY TROUT LOWEN

Minnesota’s treatment program for for criminal sex offenders has been referred to as the “Hotel California,” a nod to the 1970s song by the Eagles, the reference being that for the state’s sex offenders who are ordered by the court into the program, “you can check out any time you like, but you can never leave.” Since 1994, the Minnesota Sex Offender Program (MSOP), which currently houses offenders in razor-wire-ringed facilities in Moose Lake and St. Peter, has released just two people. The first was recommitted shortly after for violating his discharge plan. The other was released on provisional discharge in early 2012 and remains in the community.
co-editor of the book *International Perspectives on the Assessment and Treatment of Sex Offenders: Theory, Practice and Research.* “Wisconsin does a much better job of getting people out the door than we do. Texas uses outpatient civil commitment. They don’t have a facility like MSOP.”

The use of civil commitment to indefinitely confine dangerous sex offenders has grown exponentially in Minnesota since the 2003 murder of University of North Dakota student Dru Sjodin by convicted rapist Alfonso Rodriguez, Jr. Rodriguez had been released from prison after a Minnesota Department of Corrections psychologist recommended against civil commitment. In 2002, MSOP housed 181 offenders. Currently, the population is 694. By 2018, it is expected to grow to more than 1,000.

MSOP clients range in age from 19 to 90 years, with the average age being 46. They are predominantly white, almost exclusively male (there is one female); 280 are from the seven-county metropolitan area and 390 are from outside the metro. Approximately 22 percent have been committed for more than 10 years, and 75 percent for at least three years.

In response to the civil rights complaint filed by MSOP clients last August, a federal District Court judge ordered the Department of Human Services, which oversees MSOP, to create a task force to make recommendations to the Legislature on reforming the civil commitment process, less-restrictive options for housing offenders and procedures for release. In December 2012, the bipartisan task force came back with its initial report, which addressed just one of those issues. It called for the Legislature to require MSOP to develop a plan for housing some offenders in a less-restrictive environment. The task force is expected to report back on the other issues in December.

Jannine Hébert, executive clinical director of MSOP, says the program has made progress in working to release some clients. She points out that many more offenders are now in the Community Preparation Service (CPS) unit, the last stage of treatment before conditional discharge, than when she took over the program in 2008.

“We have 10 or 11 down in CPS now,” Hébert says. “Five years ago, there wasn’t anyone in CPS. That tells me that people are moving in the right direction.”

Hébert adds that she is less concerned about where clients are in the program—and how many are getting released—than about whether they

**Civil commitment**

Minnesota first enacted a law allowing for indefinite civil commitment of dangerous sex offenders in 1939. That law provided for the civil commitment of offenders with a “psychopathic personality,” that is, those who engage in habitual sexual misconduct and exhibit a lack of ability to control their sexual impulses.

Civil commitment was not often used before the 1990s. In 1994, in response to court decisions, the Legislature modified the law, allowing for indefinite commitment of individuals with a “sexual psychopathic personality,” described as someone who has engaged in harmful sexual conduct or is likely to as a result of a mental, personal or sexual disorder. After 1994, the number of civil commitments of “sexually dangerous persons,” (those who have engaged in harmful sexual conduct or who have manifested a sexual, personality, or other mental disorder or dysfunction and are likely to engage in harmful sexual conduct) began to climb.

Currently, the Department of Corrections reviews the cases of convicted sex offenders near the end of their prison sentence to determine if they meet the statutory criteria for civil commitment. If so, the state refers the case to the county in which the offense was committed. If the county attorney chooses to pursue a petition for civil commitment, the case goes before a judge who makes the final determination. As of 2003, all Level 3 sex offenders—those determined to be at the highest risk of reoffending—are automatically evaluated for civil commitment. About 50 percent of all cases reviewed result in commitment. –T.L.
have genuinely changed their behavior. Current research indicates it takes eight to nine years on average for an individual to progress through a treatment program. “That is a fair amount of time to be in treatment,” Hébert says. “These are guys who have intense pathologies and who have had opportunities to change along the way and didn’t do it. We want to make sure they’re not just going through the motions.”

The treatment
Most MSOP clients have a long-standing pattern of sexual deviance; a large percentage also have personality disorders, mental illnesses and psychopathy, a mental disorder marked by egocentric and antisocial behaviors. Clients include pedophiles and rapists as well as some who have exclusively noncontact offenses. The common denominator, says Hébert, is a long-standing pattern of offending and a high likelihood of reoffending. To address those issues, MSOP (and most successful sex-offender treatment programs) use cognitive behavioral treatment models that conform to risk-needs-responsivity principles.

The risk principle ensures that the offenders at greatest risk of reoffending get the most intensive treatment. (Research shows that over-treating low-risk offenders can actually increase their risk of recidivism.) The needs principle focuses on offenders’ criminogenic needs—those factors that are related to criminal behavior such as hostility toward women and emotional identification with children. The responsivity principle involves customizing treatment to the client—for example, considering their life experiences and cognitive abilities.

MSOP’s program is structured into three treatment phases. During Phase 1, clients learn how to comply with facility rules and learn basic treatment concepts. In Phase 2, they discuss their sexual offenses and work to understand their patterns of sexual abuse. Each client has a primary therapist and attends group sessions three times a week. In those groups, which are facilitated by two therapists, they discuss their behavior on the unit and present their assignments. Clients also attend psychoeducational groups one to five times a week. Those groups are facilitated by a therapist but are more educational.

In addition, clients participate in educational, vocational and recreational programs that provide them with opportunities to interact in more real-world type settings and for staff to assess their interactions. “I want to know how he’s doing at his history class with a female instructor. I want to know how he’s doing on his job assignment. Does he follow rules at work? If he’s a pedophile, does he have trouble interacting with adults at the gym during a therapeutic recreation opportunity? How is he interacting with his peers?” Hébert says. “We want to be sure that they’re making changes, and that they’re not just going through the motion of it. Most of them are antisocial personality types, so they are fairly talented at being manipulative and at being superficial.”

These first two phases of treatment are delivered at the Moose Lake facility. Phase 3 focuses on community reintegration; clients at this stage are housed at the St. Peter facility along with those who may have traumatic brain injuries or profound learning or developmental disabilities. Clients in Phase 3 are housed in a secure facility at St. Peter but have the opportunity to earn privileges such as staff-accompanied walks outside the secure perimeter and to and from activities on campus, staff-accompanied walks in the St. Peter/Mankato community and unaccompanied walks on campus grounds.

Clients who have earned such privileges and made sufficient progress on their treatment goals may, with approval of a Special Review Board and Supreme Court Appeal Panel, move into the CPS unit, a 23-bed residential unit located outside the secure area of the campus. In the CPS unit, clients continue to work with their primary therapist, participate in community-based treatment, and attend addiction and other support groups, vocational training, and classes on budgeting and saving, volunteering, and making healthy lifestyle choices. Clients who have met all their Phase 3 treatment goals can petition the courts for provisional discharge—a supervised release into the community.

How effective?
Although research suggests treatment programs that conform to the risk-needs-responsivity principles are most effective for sex offenders, it has been less than conclusive about those at high risk for reoffending. Two large-scale studies—one of sex-offender treatment in general and the other of the cognitive behavioral change model—produced different results. In the more general study, which was conducted in a secure forensic psychiatric hospital in California, inmates who participated in a two-year treatment program were...
monitored for eight years after release. Investigators found those who participated in the program reoffended at the same rate as those who did not. The other study, conducted by the Minnesota Department of Corrections, followed 2,040 offenders for an average of nine years. It showed a 27 percent decrease in recidivism among those who participated in a three-year intensive Department of Corrections treatment program. Neither study involved offenders who had been civilly committed.

Miner, who was involved in the initial design of the California study, says it did show some positive effects of treatment. “There was a subgroup of people who were in this treatment program who apparently benefited from it, at least got the kind of things that the treatment program wanted them to get,” he says. “And they in fact did pretty well.”

Given those results, Miner says asking whether sex offender treatment works is probably the wrong question. He suggests a better one might be “What works for whom under what conditions?”

Determining that poses additional challenges. Miner says there are no good tools to identify who has changed as a result of treatment; therefore, it’s not possible to assess when an individual’s risk level has dropped to the point where it is safe to return them to society. And because so few civilly committed offenders are ever released, it’s difficult to know whether treatment is effective. “You can’t know anything about a treatment’s effectiveness if you don’t give it a chance to succeed or fail,” he says. “And the only way to know if it succeeds or fails is to let people out.”

That decision, however, resides not with the clinic staff but with the courts. “My piece of the puzzle is providing treatment to whoever comes our way, and to do the best treatment possible, and to provide opportunities for those clients to change, and then responsibly and ethically try to reintegrate them into the community if the courts permit,” Hébert says. “I kind of have to focus on what our piece of the puzzle is. And I think our piece is pretty solid.” MM

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**Sex offender classification**

In 1996, Congress passed Megan’s Law requiring all states to develop community notification procedures when sex offenders are released from prison. The following year, Minnesota implemented the Community Notifications Act, which established a three-tier classification system for sex offenders based on their risk for re-offense.

**LEVEL 1** offenders have the lowest risk for re-offense. Notification of release is limited to victims of and witnesses to the crime, other law enforcement agencies and anyone the prosecuting attorney believes should receive the information.

**LEVEL 2** sex offenders are at moderate risk for re-offense. In addition to those included in the Level 1 notification requirements, law enforcement may also notify local schools, day-care centers and other organizations where individuals who may become victims of the offender are regularly found. Organizations are not permitted to redistribute the information.

**LEVEL 3** offenders are at the highest risk for re-offense. Law enforcement agencies are permitted to notify the community and the news media of their pending release and hold public meetings in the community where the offender will reside. Information is also posted on the Department of Corrections website.

Information can include general area of residence, a physical description (with photograph) and a description of the pattern of behavior that this offender has been known to display in the past.

Community notification is not required when clients move from St. Peter to Moose Lake or from the secure facility to Community Preparation Services. Such notification is required when clients are provisionally discharged into the community and whenever they change residences within the community. All MSOP clients are treated as Level 3 sex offenders upon provisional discharge. –T.L.